

Kansas Medical Assistance Programs

P.O. Box 3571
Topeka, KS 66601-3571

From the office of the Fiscal Agent

Please complete form and fax to EDS TPL Unit at (785) 274-5918.

Contact Name _____ Contact Organization _____
Contact Phone _____ Contact Fax _____

NOTE: The above information is necessary so we may contact you if there are questions related to this referral.

Insurance Policy Information

Add / change policy [] Delete policy []

Name of Other Insurance Company _____

Street Address _____

City _____ State _____ Zip Code _____

Phone _____

Policy Holder Name _____

Policy Holder Social Security Number _____

Policy Holder Date of Birth _____ Policy Number _____

Policy Group Number _____ Relationship to Beneficiary _____

NOTE: This box **must** be complete in order for insurance information to be added.
Failure to complete all fields will result in the form being returned.

KMAP Beneficiary Information

Name of Beneficiary	KMAP ID Number	Relationship to Policy Holder

Facsimile transmission and attachments, if applicable, contain protected health information (PHI). This information is intended only for the use of the individual or entity named in this transmission sheet. Any unintended recipient is hereby notified that the information is privileged and confidential and any use, disclosure, or reproduction of this information is prohibited. If you receive this communication in error, please contact the "Contact" person named above.